Phone: 1-877-537-0722
FAX TO: 1-877-537-0720

Division of Medicaid
Pharmacy Prior Authorization Unit
550 High St
Suite 1000
Jackson, MS 39201

For Beneficiaries under 21 Years of Age
Medical Necessity Prior Authorization Form for Children

This form is for beneficiaries under the age of 21. Reasons for prior authorization request may include, but are not limited to:

1. Request for more than 5 prescription claims per month
2. Request for more than 2 brand name prescription claims per month
3. Request for non-preferred medication

BENEFICIARY INFORMATION

Beneficiary's Name: _____ Beneficiary's Medicaid #: _____

DOB: _____ City:_____
Month/Day/4-Digit Year

PRESCRIBER INFORMATION

NPI #: _____

Prescribing Physician: _____Medicaid ID #: _____

City:_____ State: _____

Phone #: _____ FAX #:_____

Physician's signature: _____ Date:_____

I hereby certify that I am the ordering physician/nurse practitioner/physician assistant identified in this form and I deem the prescribed medication to be necessary for the patient listed. I understand that any falsification, omission or concealment of material fact may subject me to civil penalties, fines or criminal prosecution.

PHARMACY INFORMATION

Dispensing Pharmacy: _____ Provider #: _____

City:_____ State: _____

Phone #: _____ FAX #:_____

Requests for non-preferred products are subject to Division of Medicaid approval criteria. Please consult the Preferred Drug List at www.medicaid.ms.gov or call Pharmacy PA Unit for assistance at 1-877-537-0722.

REQUESTED MEDICATION	DIAGNOSIS	PREFERRED PRODUCT (Yes/No)	REQUESTED QUANTITY PER MONTH
1.			
2.			
3.			
4.			
5.			

Additional Medical Justification:

_____

MS Division of Medicaid requires that all information requested on this form be completed for consideration of approval.